

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005077	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/04/2014
NAME OF PROVIDER OR SUPPLIER DEARBORN COUNTY HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 600 WILSON CREEK RD LAWRENCEBURG, IN 47025		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>HFAP Surveyor: 34586 Facility Number: 005077</p> <p>Type of Survey: State Licensure Off Site HFAP Accreditation Survey</p> <p>Date of HFAP On Site Survey - Hospital full survey June 2-4/2014</p> <p>Date of ISDH off site review 10/22/14</p> <p>Reviewer/Surveyor --Kerry Sawin RN, PHNS</p> <p>Based on review of the June 2-4 2014 HFAP Accreditation Survey Report, it has been determined that Dearborn County Hospital meets the requirements for Hospital Licensure in Indiana for 2014.</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE